

Alliance Medical Limited

Preston PET CT Centre

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Inspected but not rated



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care to patients and monitored their pain. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for a diagnostic procedure.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Learning from incidents not always widely shared to promote learning.
- Supervisions related to incidents were not always clearly documented.
- The service level agreement with the host NHS trust was not effective in ensuring building maintenance was completed in a timely manner.
- Infection control risks in non-clinical areas were not given priority.

Summary of findings

Our judgements about each of the main services

Service

Diagnostic imaging

Rating

Good



Summary of each main service

Our rating of this service stayed the same. We rated it as good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled clinical infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

However:

- Infection control risks in non-clinical areas were not given priority.
- Supervisions implemented to address specific needs were not always documented or tracked.
- Facilities managed under a service level agreement were not always effectively maintained.

Summary of findings

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Summary of this inspection

Background to Preston PET CT Centre

Preston PET CT Centre is operated by Alliance Medical Limited. The service has been providing specialist diagnostic services since July 2007 in a purpose-built facility within an NHS hospital. Most patients are referred from NHS hospitals and services, including the hospital in which the service is based. The clinic accepted some referrals from independent providers if they were clinically appropriate.

The service delivers positron emission tomography-computed tomography (PET-CT) diagnostic imaging services to the Lancashire and South Cumbria region.

We last inspected the service in July 2019 and rated it Good overall.

How we carried out this inspection

We carried out an unannounced inspection on 13 October 2021. The inspection was carried out by a CQC inspector and a specialist advisor with support from a CQC inspection manager.

We spoke with the unit manager, the radiation protection supervisor, a PET/CT radiographer, a consultant radiologist and two members of the administration team. After our inspection we spoke with the provider's national governance lead. We looked at clinical records, equipment servicing certificates and took into account over 50 items of evidence to come to our ratings.

Outstanding practice

- The service was reviewing terminology in operational policies to reflect a gender neutral stance. This resulted from learning that gendered discussions during pre-scan consent processes marginalised some patients and presented a risk of inaccurate screening.

Areas for improvement

Action the service **SHOULD** take to improve:

- Ensure learning from incidents is shared across leadership and governance teams.
- Ensure supervisions are fully documented with outcomes tracked.
- Effectively use governance systems to ensure premises are safe and comfortable for patients, staff, and visitors.
- Ensure infection control risks in non-clinical areas are addressed promptly when they arise.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Inspected but not rated	Good	Good	Good	Good

Diagnostic imaging

Safe	Good 
Effective	Inspected but not rated 
Caring	Good 
Responsive	Good 
Well-led	Good 

Are Diagnostic imaging safe?

Good 

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. The service provided statutory and mandatory training using a combination of in-person sessions and e-learning. We reviewed the staff training matrix and found 100% compliance with completion requirements.

The mandatory training met the needs of patients and staff. Modules included basic life support, infection control, duty of candour, ethics, safeguarding, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS), health and safety, manual handling and medication safety.

Staff received training specific to their role. For example, a radiographer received further training as a radiation protection supervisor and all clinical staff undertook specialist training on nuclear medicine and administration of radioisotopes.

Radiologists working in the host NHS hospital provided reporting from the clinic when needed. The manager ensured they maintained up to date mandatory training that met the provider's internal standards. They completed mandatory training with their substantive NHS employer and provided annual confirmation of completion and revalidation.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

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Staff received training specific for their role on how to recognise and report abuse. Safeguarding children and adults formed part of the mandatory training programme and all staff were trained to level 2. The team knew how to contact the duty safeguarding lead in the host hospital and a national safeguarding lead for the provider was available on demand.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. A recent example of good practice occurred when staff contacted the duty hospital safeguarding lead to report suspected coercion and control of a young person. The team's quick actions meant a person at risk was protected from harm and supported to undergo scans important for their health. The clinic team subsequently worked with the hospital team to ensure the patient could attend appointments without the risk of control.

Staff understood how to recognise the warning signs of human trafficking and modern day slavery and knew how to get help. Where patients could not communicate in English, staff contacted the hospital to arrange for a translator to visit or used a telephone translation service.

The provider had a centrally-managed recruitment pathway that included procedures to ensure relevant recruitment checks were completed. These included a disclosure and barring service (DBS) check; occupational health clearance, references and qualification and professional registration checks. New recruits did not begin work without a DBS check in place.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They could access support from senior staff if needed. There had been one safeguarding incident in the previous 12 months.

Staff had access to a list of local safeguarding contacts, including for the out of hours crisis team. The list had last been reviewed in March 2021 and needed to be checked for updates.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Patients and visitors underwent COVID-19 safety protocols before they were able to enter the clinic. This included a temperature check, screening declaration and supervised use of hand sanitiser.

The service performed well for cleanliness and infection prevention and control (IPC). Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Radiographers were responsible for cleaning the diagnostic equipment. Items were visibly clean and dust-free, and we saw daily cleaning check lists were up to date. Staff used antibacterial cleaning products in line with best practice standards.

Staff followed infection control principles including the use of personal protective equipment (PPE). The centre provided staff PPE such as gloves, aprons, and face visors. We observed all staff wore PPE appropriately and adhered to hand hygiene best practice.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Hand-washing and sanitising facilities were available for staff and visitors in the centre. Posters were displayed prominently in waiting

Diagnostic imaging

rooms and toilets with a visual depiction of World Health Organisation hand hygiene best practice. The dedicated IPC link audited compliance with guidance using a series of rolling audits, such as quarterly observations of PPE donning and doffing and hand hygiene. Audits indicated generally good practice with more consistency needed in the removal of hand jewellery before working in clinical areas.

Staff had introduced enhanced protection measures during the COVID-19 pandemic. This included adjusting appointment arrangements to reduce the numbers of people in the building and extra cleaning for touch points around the clinic.

The scan room was clean and tidy with equipment in place to support good practice, including a sink, waste bins, and a drip stand.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had suitable facilities to meet the needs of patients' families. A dedicated waiting area with drinks, snacks and a TV was available for those accompanying patients. Visitors had use of a separate toilet.

The design of the environment followed national guidance. There were illuminated warning signs outside of the doors to the scanning room that warned of the risks of radiation and lit up when the equipment was in use. This was in line with the Ionising Radiation (Medical Exposure) Regulations (IRMER) (2017). The clinic was organised into 'cold' and 'hot' areas. 'Hot' areas were used by patients who had received a radioisotope and were waiting for a scan. Segregating them from other patients was a safety measure that avoided unnecessary additional radiation exposure to patients not yet injected. This area was self-contained and included toilets and lockers for personal possessions.

Staff carried out planned quality assurance checks of imaging equipment. This included daily checks of equipment in the dispensing laboratory and a daily PET/CT scanner check. They supplemented daily checks with a more thorough weekly scanner quality assurance review and test.

The service had enough suitable equipment to help staff safely care for patients. There was an effective system to ensure that repairs to broken equipment were carried out quickly so that patients did not experience delays to treatment. Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. We checked the service dates for all equipment and found it was up to date.

Resuscitation equipment included adult and paediatric airway support equipment, a defibrillator and oxygen. Single-use items were sealed and in date. Resuscitation equipment had been checked daily and an up-to-date checklist confirmed all equipment was ready for use. Staff maintained local emergency patient flowcharts and had updated resuscitation guidance in line with Resuscitation Council UK 2020 updates designed to protect staff from COVID-19 infection. The NHS hospital provided the emergency equipment and was responsible for its maintenance. The clinic team carried out daily and weekly safety and quality checks on the equipment to ensure it was fit for use.

The arrangements for managing waste and clinical specimens kept people safe and staff adhered to the best available techniques (BAT) in relation to the accumulation and disposal of radioactive waste in line with the Environment Agency Environmental Permitting Regulations 2010 (EPR10). This included classification, segregation, storage, labelling,

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handling and disposal of waste. For example, vials used for radioactive material were tracked and stored in a segregated area for three days before undergoing a dose check and being disposed of with clinical waste. Staff maintained a contemporaneous record of patient injections to calculate the total annual waste for monitoring by the Environment Agency.

An up to date fire evacuation plan was in place and all staff completed annual training. The service was located on the lower ground floor of the main hospital and had direct external egress to rendezvous points outside.

Staff managed sharps in line with the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 and waste in line with Department of Health and Social Care national guidance on the management of healthcare waste.

The reception area and all clinic rooms were fitted with panic alarms for staff to get help rapidly. The manager said it was very rare this system needed to be used but it was maintained and tested regularly to provide staff with a safe working environment.

The waiting room roof was leaking, and staff used fabric pads to prevent the floors becoming slippery. The ceiling was in a poor state of repair with clear water damage and flaking paint. The host NHS hospital's facilities team was responsible for premises maintenance and repairs but had not responded to three escalations from the manager since July 2021. We spoke with the director of quality and risk about this who said they would intervene to speed up the repair process.

Chairs used by patient's carers or relatives in the waiting room were in a poor state of repair, with ripped covers that presented an infection control risk. The manager had identified this risk in July 2021, and it was highlighted on the most recent IPC audit. We were unable to establish why new chairs had not been ordered.

Assessing and responding to patient risk

Staff identified, responded to and removed or minimised risks to patients. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed these regularly, including after any incident. The centre used a "pause and check" system in line with best practice guidance from the Society and College of Radiographers. The system consisted of three-point demographic checks to correctly identify the patient, the site or side of the patient's body that was to be scanned, and the existence of previous imaging.

The service had up to date local protocols for scan parameters and techniques. These had been updated in October 2021 and reflected best practice. Local rules for nuclear medicine were up to date and due for review in 2023. The rules were comprehensive, had clear input from the radiation protection advisor (RPA) and all staff had signed a log sheet to note their review in the current year.

Staff knew about and dealt with any specific risk issues. Radiographers told us how any unexpected or significant findings from image reports were escalated to the referring consultant. Staff would contact the referrer by telephone and follow this up with an urgent report.

Staff knew how to respond promptly to a sudden deterioration in a patient's health. This was sometimes possible when a patient had a reaction to the contrast used for some types of scan. All radiographers were trained in immediate life

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support (ILS) and other staff maintained certification in basic life support (BLS). Staff completed simulated emergency training and followed the provider's up to date policy in such events, including calling the hospital's resuscitation team immediately. Simulated training included a six monthly scenario of a patient having a cardiac arrest whilst in the scanner.

Staff followed risk management processes when patients were injected with radioisotope. They were required to wait for 15 minutes with the cannula in situ after the injection to ensure there would be no adverse reaction.

Staff told us they had not responded to a deteriorating patient in the last 12 months because of the nature of the service. They had received training on simulated emergency scenarios and practiced how to respond to a deteriorating patient. There was a protocol for managing a sudden deterioration in a patient's health and staff knew how to access it.

Staff used an urgent findings escalation standard operating procedure and pathway to ensure patients with immediate needs received the most appropriate care. The pathway involved a call to the referring clinician to review diagnostic findings.

The senior team implemented safety measures for patients who had an infectious condition such as COVID-19. Staff would not carry out scans on patients until they were confirmed negative. If a referring doctor requested an urgent scan for a patient who was known to be COVID-19 positive, staff liaised with them to assess the level of risk.

Staff arranged chaperones for patients on request. This could be arranged in advance or at the time of the scan.

The provider had a rapid alert system to communicate safety updates to staff. The manager was responsible for these and a plan was in place to ensure another manager acted on alerts in their absence.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and locum staff a full induction.

The manager described a stable, committed team with some staff holding over 15 years of service with the provider. The service had enough clinical and support staff to keep patients safe.

A clinical assistant provided patients with support throughout the care pathway.

All appointments were pre-booked, and the manager planned staffing levels in advance. The manager carried out risk assessments for staff to work longer shifts during persistent, exceptional demand on the service. The provider's central staffing team arranged cover from other clinics in their network to mitigate staff absence. The service did not use agency staff.

All staff completed an induction programme, which included training on use of the diagnostic imaging equipment.

The manager maintained a record of roles and responsibilities shared between staff, such as the fire marshal, health and safety lead and patient records lead.

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Radiologists from the NHS hospital carried out scan reporting in the clinic on a rotational basis. The radiologists provided reporting services as self-employed consultants under practising privileges. We saw evidence that all medical staff had valid professional registrations, medical indemnity insurance, completed mandatory training and appraisals.

Records

Staff kept detailed records of patients' care. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Staff used secure electronic patient records to record patient's diagnostic needs.

Records were stored securely. All patient's data, medical records and scan results were documented via the provider's secure patient electronic record system.

The clinic received patient referrals through a secure email or telephone call from the referring consultant or hospital.

The centre provided referrers with encrypted electronic diagnostic imaging reports.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines

The service used systems and processes to safely administer and record the use of radioactive pharmaceutical agents.

Radioactive pharmaceutical agents (radioisotopes) were administered under the authority of the Administration of Radioactive Substance Advisory Committee (ARSAC) license holder or their delegate. The provider and host NHS trust had a system of delegation in place for when this individual was away from work.

Radioisotopes were delivered up to three times per day just before they were needed. As they could degenerate quickly, this was an effective stock management system that minimised waste and disruption to the service.

Radioisotopes were stored in a secure area with restricted access. We saw staff used a safety checklist when preparing isotopes for use. This included a manual dosage machine to ensure accuracy and use of the minimum amount of dosage needed. Staff undertook point of care testing to assess a patient's risk in using the radioisotopes.

Staff carried out a stock check of contrast media every week and audited expiry dates monthly.

The service completed a quarterly medicines management audit. Records showed the service achieved 100% compliance in provider standards.

Staff documented allergies on referral forms and on the electronic patient records. Staff verbally checked allergies with each patient during the scan process safety checklist.

Incidents

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The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The service used an electronic incident reporting system and all staff we spoke with were familiar with it. Incident reporting training was part of the staff induction programme and the manager ensured staff undertook regular updates.

There were three unresolved, low-risk incidents at the time of our inspection. Each incident was independent of the other and there were no connections or themes between them. One incident involved a visitor film badge not being returned and another related to an inpatient not following a low carbohydrate diet in advance of their scan.

The service had reported two radiation incidents in the previous 12 months. One incident involved a member of staff reporting a higher dosage than colleagues and another involved a patient declining a scan after they received an injection. The team had communicated with the patient's ward nurse. They attended and helped staff work with the patient to understand their concerns. Staff arranged for a different type of scan instead and the team documented learning that where a patient presented with anxieties, they would support the patient to lie on the scan table before their injection to ensure they could tolerate it.

Staff raised concerns and reported incidents and near misses in line with the service's policy. We checked the incidents log and found incidents were reported and investigated in a timely manner.

The service had no never events, serious incidents or IR(ME)R-reportable incidents in the last 12 months.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff could give examples of scenarios that would trigger a duty of candour intervention.

Are Diagnostic imaging effective?

Inspected but not rated 

We do not currently rate effective for diagnostic imaging.

Evidence-based care and treatment

The service provided care and procedures based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice national guidance. Staff carried out scans in line with legislation, national standards and evidence-based guidance, including from the National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists (RCR), and the College of Radiographers.

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Staff followed the 10 days rule for performing scans with ionising radiation on patients who were of childbearing age. This was international guidance maintained in the UK by the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) and limited such scans to the first 10 days of the menstrual cycle.

The service's policies and procedures were subject to review by the radiation protection advisor (RPA). The annual RPA audit against the Ionising Radiation (Medical Exposure) Regulations 2017 IR(ME)R had been completed in May 2021. The audit found the service was fully compliant with the current regulations, standards and reference guidance relating to the use of ionising radiation in diagnostic imaging.

Staff adhered to the RCR evidence-based indicators for the use of PET CT in the UK.

To ensure safe radiation doses, the service applied the Public Health England guidance on National Diagnostic Reference Levels (NDRLs) when setting their local dose monitoring diagnostic reference levels (LDRLs). The LDRLs used were based on the national levels for both children and adults. The most recent audit indicated the clinic had consistently lower doses than the national average between May 2021 and September 2021. The audit system was effective. For example, in April 2021 staff identified local doses were higher than the national average and carried out investigative work to identify the cause. The team addressed the issue, which led to a reduction in the next audit month.

Staff had updated the local DRLs with lower dose readings in October 2021. The medical physicist monitored national work in dose optimisation and liaised with the provider and host NHS trust to ensure local standards reflected national best practice. The clinic manager worked with them to assess dose optimisation outcomes from other clinics in the provider's network and ensure local practice reflected the latest understanding.

One member of staff reported high doses of radiation in May 2021. The provider had implemented an investigation and identified factors that might have contributed to this. The RPA and governance team investigated this and reviewed the individual's work practices and reported lower doses after one month.

However, this individual's dose readings remained higher than the rest of the team and no further investigation or supervision of drawing up doses had been documented and there was no subsequent input from the RPA. The individual's dose rate was within safe levels but at a higher rate than the rest of the team. There was no clear reason for this, but the provider had not identified this as an area in need of further investigation.

Staff used a dose handling audit to monitor their radiation exposure. The service used a live daily record for continuous monitoring although they did not use comparative data, which meant there was limited opportunity to compare and optimise techniques.

We saw staff carried out a series of checks with patients before undertaking scans. This included a relevant medical history, history of scans, check of allergies, hydration check and the chance to ask any questions. Staff explained the hazards relating to radiation doses for the following eight hours.

The clinic held Health and Safety Executive (HSE) Registration for Ionising Radiation, including for nuclear premises.

Staff liaised with colleagues on inpatient wards to ensure patients followed a low carbohydrate diet ahead of a scan to reduce the impact of the radioisotope on heart function. Where patients had not followed this plan, the radiographer liaised with ward colleagues to identify the level of risk based on the patient's food intake.

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The registered manager joined quarterly sub specialty meetings with radiologists, the medical physicist/RPA and service support staff as part of an overarching process to ensure diagnostics were in line with national guidance and best practice. This system led to more effective practice. For example, a meeting in March 2021 highlighted an issue with the completeness of information available to radiographers caused by an IT fault. Highlighting the issue meant the cause was identified and it was resolved quickly.

The service was part of the north west head and neck clinical reference group (CRG). This was a multidisciplinary group that ensured patients undergoing investigation or treatment for head and neck cancers received care based on the latest understanding of their condition and the most effective practice.

Nutrition and hydration

Staff made sure patients did not fast for too long before diagnostic procedures.

The nature of the service meant food and drink provision was unnecessary for effective care. However water, hot drinks, and snacks were available in waiting areas

Staff offered diabetic patients an early appointment in the morning or straight after lunch to help them manage blood sugar with minimal disruption.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Staff advised patients in advance to take any prescribed pain medicine before they attended the clinic.

Diagnostic imaging patients did not routinely require pain relief. However, staff described how they would offer support to patients who reported being in pain by referring them to one of their consultants to manage it.

Staff managed pain medicine in line with Royal College of Radiologists (RCR) guidance. Patients attended from hospital wards with their own pain medicine prescribed by the consultant leading their care. Staff in the scanning clinic monitored pain and ensured patients were comfortable. No additional pain medicine was stored in the clinic and if a patient could not tolerate a scan, the procedure was cancelled, and the patient referred back to their medical team.

Patient outcomes

Staff monitored the effectiveness of care. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards. The service completed audits of report quality, the wearing of dose badges, radiation safety warning lights and signs, personal protective equipment, and imaging health and safety checklist. Results showed the service performed consistently to a high standard.

Competent staff

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The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All health care staff were registered with their appropriate professional bodies and maintained up to date training and competencies in their areas of responsibility.

All clinical staff were registered with a professional body, such as the Health and Care Professions Council (HCPC) and the Society of Radiographers.

Staff said they had received full induction tailored to their role and felt well-supported. There was evidence of completed induction. Managers made sure staff received any specialist training for their role and we saw evidence of this when we reviewed staff training files.

Managers supported staff to develop through a supervision and appraisal programme that included structured one-to-one continuing professional development sessions every quarter. The manager had maintained supervisions and appraisals despite the pressures on the service during the pandemic. At the time of our inspection, 100% of staff were up to date with appraisals. Staff said they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. A number of staff were undertaking university study and said the senior team was supportive of this.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

The clinical assistant was undertaking training courses in dementia care and cannulation in recognition of the needs of patients.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked closely with referrers to enable patients to have a prompt diagnosis and treatment pathway. If they identified concerns from scans, they escalated them to the referrer.

Staff said they had links with diagnostic imaging departments at other hospitals who they had liaised with to make use of previous images of the same person requiring the test.

Staff we spoke with told us they had good working relationships with consultants. This ensured that staff could share necessary information about the patients and provide holistic care.

Radiologists from the host hospital regularly worked in the department and attended multidisciplinary meetings to review patient care and outcomes.

The service implemented a daily operational safety huddle which was multidisciplinary. It provided a forum for staff to communicate relevant issues and escalate any concerns for immediate action. Senior regional staff attended the huddle virtually and provided support in the event of operational pressures.

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Seven-day services

The service operated five days a week from 7am to 7pm and was consistently full to capacity. Staff facilitated Saturday openings to increase capacity where cover was available.

Referrals were prioritised by clinical urgency, including appointments at short notice, and in line with contractual requirements of the referring organisations.

Staff said if an urgent referral was made the centre would assess appointments and prioritise patients according to their clinical needs and requirements of the referring consultant. Staff said patients could speak to the consultants to discuss any concerns.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients referred to the service were pre-assessed for mental capacity before they came to the clinic. However, staff had access to assessment tools and senior clinical support if they felt a patient did not have capacity to consent or make a decision.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure patients consented to treatment based on all the information available. Staff explained how they gained consent for a scan. Patients we spoke with confirmed they had been asked for, and had given, their consent for the procedure they had attended for.

Staff clearly recorded consent in the patients' records. Records also contained signed consent forms.

All clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff did not carry out scans if they did not have a clear understanding and evidence of consent or the modifications needed due to a lack of mental capacity.

We found staff asked teenagers questions about their pregnancy status when they were with a parent. This presented a risk of false information if the patient did not feel comfortable disclosing sexual activity in front of their parent. Staff said the provider was reviewing this policy to improve the consent process amongst younger patients.

Staff followed a consent protocol that included verbal and signed consent at different stages of a procedure.

Are Diagnostic imaging caring?

Diagnostic imaging

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

There was a strong, visible, person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promotes people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients we spoke with told us the centre was professional, efficient and exceeded their expectations. We spent time observing care during our inspection and saw staff were unwaveringly positive, friendly and supportive. The team had created a dedicated preparation space for patients before they began the scan process. The private space improved privacy and dignity and staff used it to answer patient's questions and concerns. We saw the space was used to provide a caring service. For example, one patient was anxious before their scan because they told staff they were having a bad day. Staff were patient and kind, listened to their concerns and gave positive, meaningful encouragement.

The results of the patient satisfaction survey showed the service was consistently rated high for compassionate care. From December 2020 to September 2021 100% of patients said they were treated with care and compassion. Comments from the survey reflected the caring approach of staff. For example, one patient noted, "Everyone was kind, thoughtful and considerate", and another patient commented, "A fantastic service, personal, friendly and attentive. Made me feel relaxed and I most enjoyed the hot chocolate after the scan, thank you."

Patients said staff treated them well and with kindness. Staff were very kind, helpful and reassuring. Patients said they received professional, personalised and holistic care.

During the pandemic staff provided information through social media to encourage patients to seek medical care for any symptoms they may experience and to raise awareness of safety steps to protect patients from COVID-19.

Emotional support

Staff provided emotional support to patients and those accompanying them to minimise their distress. They understood people's personal, cultural, and religious needs.

Staff understood the impact that patients care, treatment and condition had on the patient's wellbeing. Staff we spoke with stressed the importance of treating patients as individuals with different needs. The service had dedicated space for challenging or difficult conversations and clinicians were trained to coordinate psychological support when patients received an upsetting diagnosis. A patient said after receiving difficult news staff were very accommodating in arranging appointments for a further test and to see the consultant in outpatients.

Diagnostic imaging

Staff gave patients and those close to them support and advice when they needed it. A patient who was afraid of needles explained how staff reassured them and made them feel comfortable during the procedure. This reduced the patient's anxiety, fear and made them feel calm. The patient said the radiographer's patience and kindness helped them to cope with a difficult examination.

The service recognised the Royal College of Radiologists' 2019 recognition of comforters as people who attend a scan with a patient and knowingly expose themselves to small doses of radiation as a result. Staff supported patients to attend with comforters where this would provide them with a significantly improved experience, such as for those with claustrophobia or limited understanding of the process. Staff worked with patient's comforters and carers and made adaptations to the service to support people with emotional needs. For example, staff facilitated the presence of carers during elements of scans where this was safe, such as during the PET acquisition process. During CT scans the patient had to be alone and staff worked with them in advance of this to help assuage their nerves and concerns.

The radiation protection advisor (RPA) included a review of comforter and carer documentation in their annual audit. Staff maintained a log of this in the scan room, which helped document how they had provided additional support to patients who experienced anxiety or emotional need.

Understanding and involvement of patients and those close to them

People who use services and those close to them are active partners in their care. Staff are fully committed to working in partnership with people and making this a reality for each person.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients said staff explained the procedure, checked what diagnostic procedure they were having and checked their identity.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff encouraged each patient to complete a feedback form online following their appointment.

Patients gave positive feedback about the service. From the December 2020 to September 2021 patient satisfaction survey 98% of patients said that treatment was explained to them before any care was provided and 100% said they would be happy to return for future appointments.

Staff balanced the need to meet patient's emotional and mental health needs with the need to deliver a safe service. For example, comforters and carers were able to attend scans with patients and staff issued them with a dose pen to ensure their radiation exposure was monitored.

Staff had prepared posters to help patients understand the process of preparing radioisotopes for injection before a scan. The process was depicted graphically with supporting text and used straightforward language to help patients be more involved in their care. The team had also prepared posters depicting nuclear medicine tests. There was a photograph of each team member on display in the waiting area along with a description of their experience and roles. This helped comfort patients unfamiliar with the environment and meant they became more familiar with staff.

Staff had prepared dedicated information for patients living in care homes and the staff who worked there. This was in response to a number of patients who attended for a scan but were not prepared properly and had to be rescheduled. The information helped care home staff to prepare patients and to ensure a smooth process by advising the clinic in advance of factors that would affect the scan, such as if the patient was claustrophobic or taking steroids.

Diagnostic imaging

Are Diagnostic imaging responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of people who use the service

The service planned and provided care in a way that met the needs of people who use the service. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the people who use the service. The service provided planned diagnostic treatment for patients at their convenience.

Patients referred with an Administration of Radioactive Substance Advisory Committee (ARSAC) approved referral were seen within seven days. Patients referred within a cancer pathway were seen within seven days in line with the national standard. In the previous 12 months the service was 100% compliant with this standard and reported no breaches.

Managers monitored and took action to minimise missed appointments. Missed appointments were recorded electronically and patients contacted to rebook appointments. The outcome of each contact was recorded. Appointments cancelled by the service amounted to 1.3% of total visits.

We saw staff gave patients a good introduction to the scan process and explained each step clearly. They offered patients the opportunity to ask questions and ensured they were comfortable with the process before proceeding. Staff checked each patient's adherence to guidance before the scan, such as fasting or modified diets. Patients told us staff had clearly explained how they would get their results. Where patients were referred to the service from an inpatient ward, staff explained how they would obtain their results if they were discharged before they were finalised.

Staff followed care pathways such as a deteriorating patient pathway and significant pathology pathway to ensure scan results were shared appropriately as part of each patient's wider investigations.

The manager had implemented a new pre-scan area. This was a private area in which staff carried out COVID-19 screening and spent time with patients to ask them questions about their pre-scan activity and address any concerns. It provided a quiet, clinically safe space for staff to carry out preparation work.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

There was a comfortable seating area, cold water fountain, drinks machine for making hot drinks and toilet facilities for patients and visitors.

Diagnostic imaging

Managers made sure staff, and patients, loved ones and carers could access interpreters or signers when needed. Interpreters were arranged in advance either in person or by phone. Where staff were unaware of a language need or they felt a patient could not adequately understand the procedure due to language needs, they used an on-demand phone interpretation service. The provider website included safety information and forms in the languages most often used by patients.

The clinic was fully step-free from the street to all clinical areas. It had toilets that could be accessed by people using a wheelchair.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. A hearing loop was available to assist patients wearing a hearing aid. The service had resources for patients with learning difficulties such as a healthcare communication resource book, which included easy read formats, Makaton signs, and symbols for nursing and patient needs.

Staff planned care for patients living with learning difficulties or dementia in advance. This enabled them to modify investigations and assist with planning for the patient's appointment. All staff undertook training in communicating with patients living with learning difficulties or dementia and offered patients the opportunity to visit the clinic and acclimatise themselves to the environment and equipment. This reflected good practice and helped to reduce patient's anxieties.

Staff made sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet their needs. The centre had a dementia champion and resources for patients with mental health problems and dementia. During the COVID-19 pandemic the service made arrangements for patients with additional needs to have a relative or carer to support them, while other patients were asked to attend alone.

Patients had access to a private locker to store their personal belongings during scans.

On referral from an NHS doctor, the clinic sent out a letter explaining the process and what the patient should do to prepare in advance. We spoke with a patient who said they had appreciated the level of detail in their letter. They said a member of staff had called them the day before the appointment to confirm arrangements and answer any questions they had.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to test and from test to results were in line with national standards.

Patients were referred by local NHS trusts, including the host hospital, and an independent health provider with occasional referrals by GPs. The senior team said there had been a significant increase in demand and opening hours and capacity had been extended to accommodate this.

The service offered self-referrals following a triage process by a radiographer or radiologist to ensure they were appropriate. Systems were in place to ensure appointments were safe. For example, non-medical referrals were not accepted, and results were delivered from the patient's GP.

Diagnostic imaging

Diagnostic reports were usually made available within 24 hours depending on the urgency of the request and investigation. There was a dedicated pool of radiologists. Images were reported in time order unless it was clinically urgent which would be flagged.

The service audited patients waiting times on arrival at the centre. Patients were to be seen within 15 minutes of arrival at the centre. Records showed that staff consistently achieved 100% compliance.

Staff called each patient the day before their appointment to ensure it was still convenient and they planned to attend. This helped to reduce wasted appointments from non-attendance and meant staff could identify any additional needs for which they needed to prepare. The service maintained a did not attend (DNA) rate of 4% and the manager monitored local conditions that might impact this such as COVID-19 infection rates and fuel shortages. The manager called each patient who did not attend a booked appointment and reported figures weekly to NHS trusts where their referred patients had not attended.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The provider had a complaints policy and a central quality and complaints team to support the local clinic manager. The policy outlined how complaints were acknowledged, investigated and resolved and included guidance for patients if they were unhappy with the outcome. The provider's standard was to acknowledge a complaint within 48 hours and to provide a full response within 20 working days.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas and the website.

Managers shared feedback from complaints through emails and meetings and learning was used to improve the patient's experience. We spoke with staff who were able to identify how to support a complaint, be it informal or formal, and how it was escalated and managed by senior managers. Staff could give examples of how they used patient feedback to improve the service. For example, changes were made to strengthen the pre-assessment process.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. There had been six complaints in the previous 12 months. Two complaints related to the information provided after a scan was sent to the patients' GPs. In each case the radiologist reviewed the scans, produced an addendum with additional information and contacted the patient and their GP.

The governance lead maintained oversight of all formal complaints until they were resolved. They discussed the progress of each during weekly service manager meetings with input from senior imaging staff.

Are Diagnostic imaging well-led?

Our rating of well-led stayed the same. We rated it as good.

Diagnostic imaging

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The provider was undertaking a restructure of leadership roles and functions at the time of our inspection. The current registered manager led this location plus another diagnostic imaging site in the provider's regional portfolio. This role would change in early November with a single-site manager and a clinical lead supported by a clinical head of PET/CT. The restructure had been planned for some time and reflected the provider's approach to ensuring sustainability of the service and included succession planning for staff moving to more senior roles.

The senior team had set priorities and strategies that ensured leadership was sustainable, compassionate, inclusive and effective. Staff told us they were well supported and had access to senior leaders even if there was no manager on site. They spoke positively of the provider's approach to their mental health and well-being during the pandemic and noted they were proud to work in the service. Leaders provided clear, consistent support for staff to progress to more senior roles with training and guidance.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The provider had a national vision and strategy focused on excellent patient care and sustainability. The manager and team demonstrated a good understanding of this and how it applied to their work in this specific clinic.

The manager introduced the provider's vision and strategy at the point of interview to test how an individual's experiences and work ethic reflected these. They considered examples given by new applicants to better understand how they interpreted the organisation's corporate values.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with were proud of the work that they carried out. They enjoyed working in the clinic; they were enthusiastic about the care and services they provided for patients. They described the clinic as a good place to work.

Staff said they felt that their concerns were addressed, and they could easily talk with their managers. Staff reported that there was a no blame culture when things went wrong, and they knew how to access the provider's whistleblowing process.

Diagnostic imaging

Patients told us they were very happy with services and did not have any concerns to raise. They felt they were able to raise any concerns with the team without fearing their care would be affected

Staff adopted areas of responsibility such as imaging report management lead, research lead, and clinical liaison. This ensured staff built and maintained senior and cross-specialty skills and supported an open working environment that valued good communication.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

An integrated governance and risk board was accountable for the service, with contributing leadership and governance from five committees, including a clinical governance committee and a radiation protection committee.

The governance team prepared a monthly quality assurance report that included a view of all aspects of the service. Meeting actions showed the senior team was aware of areas for action but had not acted swiftly. For example, the most recent report indicated two members of staff had expired information governance training and the outcomes of three low-risk incidents were overdue.

The manager attended quarterly sub-specialty meetings with the host NHS trust. Radiologists, the RPA and business managers attended the meetings. We reviewed the minutes from the last three meetings and saw evidence of good exchange of information between the provider and the trust in a manner that enhanced safety and effective care. Attendees used the meetings to review specific types of scan, including those that required enhanced contrast, and consider if these were consistent. The group had a clear problem-solving function and there was documented evidence of good practice that reflected a collaborative culture of safety and learning.

The manager attended weekly service manager meetings with the Head of operations and senior imaging staff. The team reviewed incidents, complaints, national updates, safety alerts, and patient feedback. They used this meeting to review staffing and pressures on the service and it was a structured forum in which to solve problems and share learning.

The radiation protection committee met quarterly and fed into the patient safety and quality group and the corporate radiation protection committee. Risk assessments, incidents and action plans were discussed.

The service had effective systems, such as audits and risk assessments, to monitor the quality and safety of the service.

Learning was cascaded to staff through staff work email accounts, team meetings, training, and governance updates.

The service carried out a comprehensive monthly health and safety audit that included a review of equipment testing, statutory health and safety notices, completion of the visitor's log and fire safety checks.

A medical physics expert/radiation protection advisor provided oversight for the clinic and attended quarterly safety meetings.

Diagnostic imaging

Radiographers and support staff undertook a monthly radiation review with a clinical lead to ensure dose management was appropriate and within safe limits. All classified radiation workers were subject to an annual medical by a HSE appointed medical clinician.

Staff carried out regular quality assurance checks on the PET-CT scanner. We saw these quality assurance checks were completed consistently with no gaps.

The service sought oversight from appropriate professionals to ensure practices were compliant with legislation, regulation, and national best practice. A radioactive waste advisor provided comprehensive guidance to help staff manage waste in line with Environment Agency requirements.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

A mobile planning team was on call at all times the service was in operation. Local staff escalated equipment failures or concerns to the team, who arranged for a rapid response from maintenance staff. Where repairs were not possible, the mobile team identified the nearest alternative facility for patients to be redirected or for mobile equipment to be set up.

The service had contingency plans in place to minimise service disruption in the event of scanner failure. This demonstrated highly effective contingency plans during service disruption. For example, if the scanner failed and could not be repaired quickly, the mobile scanning team and manager would arrange for a mobile scanner to be installed on the site of a local hospital. The site had its own power supply for connection of a mobile scanner and the existing service toilets would be used. The clinic team would call all patients who would be impacted and arrange for their scans to take place at the alternative site.

All operational licenses were up to date.

The Radiological Protection Centre had published an audit for services in the north region in June 2021. This site was omitted from the overall findings although exception findings from other sites were shared for learning. Overall reportable incidents were very rare and there was evidence of a good standard of input from specialists, including the medical physics expert.

The manager maintained up to date risk assessments including for all aspects of radiation risk occurring on site and a list of authorised operators for nuclear medicine and CT scans. Practitioner licenses were available on site and were up to date. We reviewed the service records for the PET/CT scanner and found consistently good practice including handover forms between staff and service engineers and rapid action from staff when they found a potential fault.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Diagnostic imaging

Staff checked referral summaries to ensure patients were within their contractual remit. Where patients were outside of this, the manager liaised with the referring doctor to resolve the situation.

Radiation reporting was managed by the NHS trust. The manager worked closely with the information governance team to ensure information was managed in accordance with a data sharing agreement.

Staff in the clinic did not have access to NHS trust IT systems. This meant they relied on clinical information provided by the referring doctor for patients referred from wards. However, the centre did have access to the host site Radiology Information System (RIS).

The provider contributed to the national diagnostics information dataset (DIDS) in 2020-2021 as part of good practice to assess the completeness of information security. The results showed 98% of records kept by the service included the patient's NHS number and 79% of accepted referrals included the referrer's General Medical Council (GMC) number. The service held ISO27001:2013 status, which indicated nationally-compliant standards of information security and governance.

Engagement

Leaders and staff actively and openly engaged with patients and staff, to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff said they received regular well-being updates. For example, information on maintaining mental health during the COVID-19 pandemic.

Staff spoke positively about working for the provider and about support from managers. There was a clear focus from the senior team on supporting staff development and a number of staff were undertaking advanced training.

The manager recognised the impact of additional pressures on the service on staff mental well-being. This provided on-demand support and encouraged staff to use the provider's external arrangement with a counselling service.

The service demonstrated a strong track record of engagement with staff to ensure they could work effectively and achieve a good work-life balance.

Team meeting minutes demonstrated a two-way exchange of information, with audit and performance results available to staff and evidence of a receptive senior team that listened to feedback. Discussion topics included security updates and a planned IRMER audit.

Staff told us they felt the manager and provider worked to ensure they maintained a good work-life balance such as by supporting flexible working and ensured there was a choice of annual leave available.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Diagnostic imaging

The service was participating in a national research programme that aimed to improve scans for people living with dementia. The provider had worked with the investigation team to ensure the research adhered to ethics criteria.

The provider was in the process of adapting consent processes to make them more accessible to patients. This included the introduction of gender neutral language and new processes to gain consent from young people who arrived with a parent but who may not wish to disclose information important to scan safety, such as pregnancy status.